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No. 90-1964

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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1991

THE COLORADO DEPARTMENT OF SOCIAL SERVICES,
Petitioner,
vs.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; LOUIS W. SULLIVAN, M.D.; NORVAL SETTLE; ALEXANDER TEITZ; and JUDITH BALLARD, in official capacities,
Respondents.

REPLY TO RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

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ARGUMENT

A. The States Remain Subject to Disallowances for Missed Patients in Inspections of Care.

The Department of Health and Human Services ("HHS") concedes that the Federal Courts of Appeal have split on the issues presented by this case, but argue that the conflict is of limited significance. The conflict remains significant to the States, for if the conflict is not resolved, HHS will be free to continue taking substantial disallowances contrary to the intent of Congress.

The cases which created the conflict between the circuits for which review is sought here construe existing Federal regulations which implement the inspection of care ("IOC") process for certain long-term care facilities. 42 C.F.R. § 456.652 (1988). Since the initiation of the subject disallowances, Congress has substituted a sampling technique for the 100 percent inspection of patients in nursing facilities including those formerly known as intermediate care facilities ("ICFs") and skilled nursing facilities ("SNFs") (Act of Dec. 22, 1987, Pub. L. No. 100-203 1988 U.S. Code Cong. & Admin. News (101 Stat.) 1330-212, 213, applicable as provided by § 4214 of such Act). However, the subject regulations continue to apply to intermediate care facilities for the mentally retarded ("ICFs-MR") and institutions for mental diseases ("IMDs").

Many penalties have been taken by HHS against the States regarding "missed" inspections of patients in ICFs and SNFs, despite the States' "good faith and due diligence" and contrary to the direction expressed by Congress in 42 U.S.C. §1396b(g)(4)(B) (1985). As HHS now has lost its ability to take disallowances based on the failure to perform 100 percent review of those facilities, it may direct its attention to the facilities remaining subject to IOC requirements to access further disallowances, trivially characterized by HHS as "limited discrepancies in apportionment," to the benefit of the Federal government at the expense of the States.

As HHS states, HCFA has taken steps, through its many disallowances and its rather late-coming Transmittal No. 4, §9155, State Medicaid Manual, Pt. 9 (Utilization Control), not issued until January of 1988, to "inform" the States that they may not rely on facility-generated information to determine which Medicaid patients are in facilities subject to inspection of care. The States are aware of the possibility that at least one patient may be missed due to an unintentional error of the facility generating its census

list.[1] However, information from other sources has proved difficult to obtain and to be of questionable reliability. HHS has offered no realistic alternative method for verification. Even with the implementation of burdensome additional processes to gather patient information, Colorado continues to depend primarily on the facility's census. Therefore, the potential for future disallowances continues.

Although HHS argues that the IOC inspection requirements are no longer significant, its actions speak otherwise. The District Court in *Arkansas v. Sullivan,* No. LR-C-88-793 (E.D. Ark., Oct. 18, 1990) rendered its decision (Appendix "A") reversing a disallowance taken for Arkansas' failure to review one patient in an ICF, on October 18, 1990, *after* the effective date of the subject statutory amendment. Nevertheless, HHS appealed that decision which now is pending in *Arkansas v. Sullivan*, No. 90-3100 EA (8th Cir.).

For years, the States have suffered disallowances of substantial sums of money at the hands of HHS due to the Agency's refusal to give the States the benefit of the exceptions Congress granted to them. Only now have the States' appeals advanced to this level of review. The Federal Government should not be allowed to continue taking unlawful disallowances in some jurisdictions just because it may not be able to take as many of them now as it has taken in the past.

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[1]HHS has presented no evidence that any facilities have intentionally omitted patients from review or that any patients omitted from facility census lists have been subject to abuse or neglect.

B. Disallowances Taken Against Colorado Would be Reversed or Remanded by this Court's Determination that the Subject Regulations are Unreasonable.

HHS contends that even had the Court of Appeals for the Tenth Circuit found the HHS "safe harbor" regulations unreasonable by adopting the approach taken by the District Court in *Delaware Division of Health and Social Services v. Department of Health and Human Services*, 665 F. Supp. 1104 (D. Del. 1987) and by the Third Circuit in *Pennsylvania Department of Public Welfare v. Department of Health and Human Services*, 928 F.2d 1378 (3d Cir. 1991), Colorado would not meet even the subjective standard expressed by those courts. This contention cannot be supported by the record in this case.

Even had Colorado utilized Peer Review Organization eligibility information as suggested by the Departmental Appeals Board ("DAB"), only two of the three omitted patients would have been reviewed. By the regulations at issue here, missing even one patient would subject the State to the same penalties as though it had failed to inspect the facility altogether. Had other Medicaid billing information been used for verification, its untimeliness would not have avoided the disallowance.

The proceedings before the DAB were conducted only pursuant to the existing regulations of HHS. The DAB, in its quasi-adjudicative function, must follow regulations promulgated in its quasi-legislative function. *Arizona Grocery Co. v. Atchison, Topeka, & Santa Fe Railway Co.*, 284 U.S. 370 (1931). Therefore, Colorado did not present argument and evidence to the DAB to meet the requirements of alternative regulations which were beyond the authority of the DAB to adopt. Upon review of this Court, if any question remains whether Colorado meets the exception under the proper statutory interpretation, the case

should be remanded back to the DAB as was done in *Pennsylvania Department of Public Welfare v. Department of Health and Human Services, supra*.

CONCLUSION

The Petition for Certiorari should be granted.

Respectfully submitted,

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APPENDIX A

IN THE UNITED STATES DISTRICT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

STATE OF ARKANSAS, BY ITS
DIRECTOR OF THE DEPARTMENT OF
HUMAN SERVICES, DR. TERRY
YAMAUCHI PLAINTIFF

v. Civil No. LR-C-88-793

LOUIS M. SULLIVAN, M.D.,
IN HIS OFFICIAL CAPACITY AS
SECRETARY OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES, and
THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES DEFENDANTS

JUDGMENT

In accordance with the Memorandum Opinion and Order entered this date, judgment is entered in favor of plaintiff and against defendants. Defendants' disallowance is arbitrary, capricious and contrary to law. Defendants are permanently enjoined from taking any steps to recover disallowed funds from the State paid under the Medicaid program for payment of services in ICF facilities for the period ending June 30, 1987.

IT IS SO ORDERED this 18 day of October, 1990.

_____
GEORGE HOWARD, JR.
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

STATE OF ARKANSAS, BY ITS
DIRECTOR OF THE DEPARTMENT OF
HUMAN SERVICES, DR. TERRY
YAMAUCHI PLAINTIFF

v. Civil No. LR-C-88-793

LOUIS M. SULLIVAN, M.D.,
IN HIS OFFICIAL CAPACITY AS
SECRETARY OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES, and
THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES DEFENDANTS

MEMORANDUM OPINION AND ORDER

The State of Arkansas brings this action challenging the determination by the Department of Health and Human Services ("HHS") disallowing federal funding claimed by Arkansas under the Medicaid program of the Social Security Act ("Act") for the quarter ending June 30, 1987. The disallowance is based on the failure of Arkansas to timely review one patient in an intermediate care facility ("ICF"). This Court has jurisdiction pursuant to 5 U.S.C. §701 et seq. *See Bowen v. Massachusetts*, 108 S.Ct. 2722 (1988).

FACTS

"The Medicaid program was created in 1965, when Congress added Title XIX to the Social Security Act ... for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). In exchange for federal Medicaid payments, each participating state must submit a "state plan" which meets certain conditions specified in the Act.

At issue in this case are the requirements that each state conduct periodic inspections of ICFs and that the state have an effective program of review of medical care of patients.

On March 31, 1988, the Health Care Financing Administration ("HCFA") of HHS notified the Arkansas Department of Human Services ("State" or "Arkansas") that HCFA was reducing federal financial participation ("FFP") for amounts Arkansas claimed for ICF services under the Medicaid program. The disallowance, originally amounting to $212,614.00, was made pursuant to HHS' determination that the State had failed to make a satisfactory and valid showing that there was in operation an effective program for medical review of the care of ICF patients for the calendar quarters ending June 30, September 30, and December 31, 1987. HHS concluded that the State's showing was unsatisfactory due to the State's alleged failure to review the quality of care of one patient for one quarter in one ICF, and one patient for three quarters in another ICF.

During the course of the appeal to the Departmental Appeals Board ("DAB"), HCFA withdrew the disallowance at one facility for the September 30 and December 31 quarters. Thus, the DAB considered the disallowances involving two ICF residents residing in different facilities for the June 30, 1987 quarter.

The DAB issued its decision on October 17, 1988. It reversed the disallowance as to one resident at Crestpark, an ICF, finding that the failure to conduct a medical review on that patient was not the State's fault. In particular, the State had designated the patient for review but the administrator of the facility had mistakenly informed the State inspection team that the resident had been transferred and was no longer in the facility. Although the transfer documents for the patient had been completed, the patient did not actually leave the facility until the day after the inspection. The DAB found that "the failure to review the patient did not result from a systemic flaw in the State's patient identification process." DAB Decision 992, p. 5. The DAB reversed HCFA's finding of a deficient review at Crestpark.

At Nashville, another ICF, the State conceded that one patient was not reviewed. The State attributed the failure to conduct a timely review to "human error," i.e., the State could not offer any particular explanation for its failure to review the patient.[2]

The DAB found that Arkansas' explanation was in essence no explanation and therefore it could not invoke a statutory exception to the annual review requirement. Thus, the DAB sustained the disallowance for Nashville.

The DAB directed the parties to establish the reduced amount of the disallowance. If they could not agree upon an amount, the DAB would determine it.

Arkansas appealed the decision. Arkansas argues that HCFA seeks to recover $62,067.00 for Arkansas' failure to review one patient in one facility.

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[2]This patient, however, was ultimately reviewed in late September, 1987.

APPLICABLE STATUTES AND REGULATIONS

Pursuant to 42 U.S.C. §1396b(g)(1)(D), in any calendar quarter for which a state submits a request for payment for ICF services furnished, the state must make a "showing satisfactory to the Secretary" that it has "an effective program of medical review of the care of patients" in ICFs "whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams."

A state Medicaid plan must provide with respect to each ICF within the state

> (B) . . . for periodic inspections of the care of each person receiving medical assistance, by one or more independent professional review teams . . . , including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services . . .

42 U.S.C. §1396a(a)(31)(B).

Unless a state makes a satisfactory showing of an effective utilization program as required by section 1396b(g)(1) and 1396a(a)(31), the total amount of federal Medicaid reimbursement to the state is reduced according to a statutory formula. 42 U.S.C. §1396b(g)(5).

Section 1396b(g)(4)(B) provides a statutory exception to

the annual review requirement. Thus, according to the statute, the Secretary shall find a showing to be satisfactory

> (B) . . . if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter --
>
> (i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and
>
> (ii) in every such hospital or facility which has 200 or more beds,
>
> and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

HHS promulgated regulations implementing the statutory provision. Pursuant to 42 C.F.R. §456.653, an agency's showing will be satisfactory, even if it failed to meet the annual review requirements, if

> (a) the Agency demonstrates that --
>
> (1) It completed reviews by the end of the quarter in at least 98 percent of all facilities requiring review by the end of the quarter;
> (2) It completed reviews by the end of the quarter in all facilities with 200 or more

certified Medicaid beds requiring review by the end of the quarter; and

(3) With respect to all unreviewed facilities, the agency exercised good faith and due diligence by attempting to review those facilities and would have succeeded but for events beyond its control which it could not have reasonably anticipated; or

(b) The agency demonstrates that it failed to meet the standard in paragraph (a)(l) and (2) of this section by the close of the quarter for technical reasons, but met the standard within 30 days after the close of the quarter. Technical reasons are circumstances within the agency's control.

STANDARD AND SCOPE OF JUDICIAL REVIEW

A reviewing court shall set aside an agency's action which is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. 5 U.S.C. §706(2)(A); *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). In general, courts afford deference to an agency's construction and interpretation of the statute. A court's deference is not absolute, however. A court will invalidate as contrary to law regulations which are found to deviate from Congressional will. *Cambridge Hospital Association v. Bowen*, 655 F.Supp. 439, 441 (D. Minn. 1987). Furthermore, a "court need not accept an agency's interpretation of its own regulations if that interpretation is inconsistent with the statute under which the regulations were promulgated, is plainly inconsistent with the wording of the regulation, or otherwise deprives affected parties of fair notice of the agency's intentions." *Oglala Sioux Tribe of Indians v. Andrus*, 603 F.2d 707, 718 (8th Cir. 1979).

ANALYSIS

Arkansas relies on the court's holding in *Delaware Division of Health and Social Services v. U.S. Department of Health and Human Services*, 665 F.Supp. 1104 (D. Del. 1987) to support its argument that HHS' action must be reversed. In *Delaware*, the state had failed to review four patients in two facilities. The state asserted that the patients had not been reviewed because "'[f]or some unknown reason their names had been deleted inadvertently from the regional Medicaid list'". **Id.** at 1114. The Review Board upheld HHS' decision to disallow Medicaid funding for the two facilities for two quarters of 1984.

The court reversed HHS' disallowance. The court found that HHS' regulations interpreting the statutory language that state agencies "conduct" on-site inspections to mean "complete" reviews were arbitrary and capricious. It further found that HHS' regulation defining "good faith and due diligence" was arbitrary and capricious as it is more restrictive than the standards provided for in the Act and in conflict with the language of the statute.

The *Delaware* court also found that the Secretary's interpretation of the regulations and statute--including the "good faith" and "technical failing" exceptions--were arbitrary and capricious.

HHS argues that the reasoning in *Delaware* is flawed, that the statute requires that review of each patient in each facility is a requirement, and that the reviews be completed, not merely conducted.

The Court need not decide the issue of whether the regulation requiring the review be completed conflicts with the statutory mandate that annual reviews be conducted on each patient. The Court agrees with the decision in *Delaware* that the regulation interpreting good faith and due diligence is inconsistent

with the congressional purpose and unreasonably restrictive.

The Good Faith Exception

The regulations interpret "good faith and due diligence" to mean "circumstances beyond the agency's control." 42 C.F.R. §456.653. The HCFA's commentary accompanying the regulation states: "We believe that the inherent meaning of the phrase 'good faith and due diligence' is that the State agency made attempts to perform reviews but was prevented from doing so by circumstances over which it had no control." As examples of such circumstances preventing review, HCFA lists inclement weather or a quarantine of the facility. 44 F.R. 56336.

The legislative history surrounding the "good faith" exception reveals that Congress did not intend as limiting an exception as that contained in the regulations. The Conference agreement rejected the harsh language of the Senate amendment which would have provided that the Secretary could waive any reduction in Medicaid payment if the Secretary determines that the State's noncompliance is technical or due to circumstances beyond control of the State. Rather, the conferees agreed on a subjective standard, that is that the state make good faith attempts to perform reviews of all institutions, and actually review all large institutions and 98 percent of all other institutions. "If a facility is not reviewed, there will be a reduction in matching unless the Secretary finds there was a good faith attempt to review the institution, and there is no evidence that any institution, or kind or type of institution, is deliberately not reviewed." H.Rep. No. 95-673, 95th Cong., 1st Sess. 48 (1977), reported in U.S. Code Cong. & Admin. News 1977, pp. 3039, 3122.

Thus, the Conference agreement explicitly rejected the language the Secretary added to the regulations for the good faith" exception. The Secretary's requirement of demonstrating circumstances beyond the control of the agency is clearly more

demanding than that desired by Congress, i.e., that the state make a "good faith attempt" at 100 percent review, and that failure to do so not be deliberate.

"The Social Security Act, because of its remedial purposes, must be broadly construed to favor the intended beneficiaries of the Medicaid program." 665 F.Supp. at 1122. Thus, while Congress is concerned with the adequacy of care provided patients in long-term care facilities, the need to provide adequate funding for patient care cannot rest on hypertechnical, inflexible requirements. Thus, the Court is persuaded that Congress intended that states be allowed some level of tolerance for **de minimis** errors, where such errors are not deliberate or systemic.

The Court finds that the Secretary's regulation defining the "good faith and due diligence" is inconsistent with the purposes and policies embodied in the statute, and is more restrictive than the statutory mandate. As such, the regulation is contrary to law and must be set aside. *See Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123, 131 (9th Cir. 1980).

The Court also finds that the DAB's finding that Arkansas had not exercised good faith and due diligence is arbitrary and capricious. The Court notes that Arkansas had reviewed all patients in all facilities, save one. Certainly, this near 100 percent compliance falls within the legislative mandate that the State made a good faith attempt to review the institution, and its failure to timely review one patient was inadvertent.

CONCLUSION

The Court finds that HHS' disallowance is arbitrary, capricious, and contrary to law. In particular, the Court finds that the regulation interpreting "good faith and due diligence" is void and the Board's interpretation of that regulation is arbitrary and

capricious. The. decision of the DAB is reversed. HHS is permanently enjoined from taking any steps to recover disallowed funds from the State paid under the Medicaid program for payment of services in ICF facilities for the period ending June 30, 1987.

IT IS SO ORDERED this 18 day of October, 1990.

_____

GEORGE HOWARD, JR.
UNITED STATES DISTRICT JUDGE